

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9657

CERTIFICATE OF DEATH

Reg. Dist. No. 09644 282

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn				c. LENGTH OF STAY IN 1b 2 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital				d. STREET ADDRESS Dameron			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Henry Middle Francis Last Cullison Jr.				4. DATE OF DEATH Month 9-20-56 Day 19 Year 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-20-56	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 1 Days 57		IF UNDER 24 HRS. Hours 1 Min 57			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY Infant		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Henry Francis Cullison Sr.				14. MOTHER'S MAIDEN NAME Geraldine Sexton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT Geraldine Sexton Cullison, Dameron, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 761.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Premature Separation of Placenta DUE TO (c) Premature Separation of Placenta				INTERVAL BETWEEN ONSET AND DEATH 1 3/4 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9/20 , 19 56 , to 9/20 , 19 56 , that I last saw the deceased alive on 9/20 , 19 56 , and that death occurred at 2:15 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. D. Byrd M.D.				ADDRESS (Street, city or town, state) Leonardtwn DATE SIGNED 9/20/56			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/20/1956		22c. NAME OF CEMETERY OR CREMATORY St. James		22d. LOCATION (City, town, or county) (State) Park Hall Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				ADDRESS Leonardtwn, Md.		24a. REC'D BY REGISTRAR 9/20/56	
24b. REGISTRAR'S SIGNATURE Glenn D. Hauser							

2078233XVI

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text, possibly "JOHN DOE"]</p>		<p>2. SEX [Faint text, possibly "Male"]</p>	
<p>3. AGE [Faint text, possibly "45 years"]</p>		<p>4. DATE OF DEATH [Faint text, possibly "1956-09-21"]</p>	
<p>5. PLACE OF DEATH [Faint text, possibly "Home"]</p>		<p>6. CAUSE OF DEATH [Faint text, possibly "Heart Disease"]</p>	
<p>7. MANNER OF DEATH [Faint text, possibly "Natural"]</p>		<p>8. SIGNATURE OF PHYSICIAN [Faint signature]</p>	
<p>9. SIGNATURE OF REGISTRAR [Faint signature]</p>		<p>10. SIGNATURE OF WITNESSES [Faint signatures]</p>	

BUREAU V. 1

SEP 21 1956

RECEIVED

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1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09645
9658 CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>				c. LENGTH OF STAY IN 1b <u>2 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Piney Point</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Mary's Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>C.</u> Last <u>Dickins</u>				4. DATE OF DEATH Month <u>September</u> Day <u>17</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 16 1885</u> 71 yrs.	
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Henderson Blackwell</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Henry B. Dickins, Piney Point Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Sept 14, 1956</u> to <u>Sept 17, 1956</u> , that I last saw the deceased alive on <u>Sept 16, 1956</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P. J. Bean</u> M.D.				ADDRESS (Street, city or town, state) <u>Great Mills Md.</u> DATE SIGNED <u>9/17/56</u>			
PHYSICIAN'S NAME (Type) <u>P. J. BEAN</u> M.D.				<u>GREAT MILLS</u> MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/19/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. LUKE'S</u>		22d. LOCATION (City, town, or county) (State) <u>Piney Point Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. CLARKE MATTINGLET, LEONARDTOWN, MD.</u>				24a. REC'D BY REGISTRAR <u>9/17/56</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

RECEIVED

SEP 24 1956

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

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1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9659
CERTIFICATE OF DEATH

09646

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY Saint Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Conn. Maryland b. COUNTY Saint Mary's HARTFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridge	c. LENGTH OF STAY IN 1b 17 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridge, Maryland BROAD BROOK 45X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Station Hospital, USNAS Patuxent River, Maryland		d. STREET ADDRESS RURAL MILL STREET	
3. NAME OF DECEASED (Type or print) First Middle Last Gail Ann DUCHARME		4. DATE OF DEATH Month Day Year September 2 19 56	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-17-56
9. AGE (In years last birthday) yrs. Months Days 17		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Edward DUCHARME		14. MOTHER'S MAIDEN NAME Arline Kreyssig	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Richard Edward DUCHARME, Ridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 7630 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 12 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. 0925 D O. A. 9-2-56 ACTUAL SIGNATURE G. C. Ramsay M.D. Station Hospital, USNAS DATE SIGNED 9-2-56 PHYSICIAN'S NAME (Type) G. C. RAMSAY LT MC USNR Patuxent River, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation 9/4/56		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Leonardtwn, Md.		22d. LOCATION (City, town, or county) (State) Windsor Locks, Connecticut	
23. FUNERAL DIRECTOR'S SIGNATURE G. B. Robinson		24a. REC'D BY REGISTRAR DATE 9/4/56	
24b. REGISTRAR'S SIGNATURE G. B. Robinson			

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BUREAU V. S.

SEP 5 1956

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1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09647
9660 CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b 3 hrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. George Island		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAGGIE Middle EVANS Last EVANS		4. DATE OF DEATH Month September Day 3 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1876
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 79 Days 79 Hours 79 Min. 79	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Robert Evans		Address St. George Island, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis occlusion 420.1 DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Coronary thrombosis (c) Coronary thrombosis INTERVAL BETWEEN ONSET AND DEATH 2 hours 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 13, 1957 , to Sept 3, 1956 that I last saw the deceased alive on Sept 2, 1956 , and that death occurred at 12:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Great Mills, Maryland DATE SIGNED 9/4/56 ACTUAL SIGNATURE P. J. Bean M.D. PHYSICIAN'S NAME (Type) P. J. Bean 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9/6/1956 22c. NAME OF CEMETERY OR CREMATORY Poplar Hill 22d. LOCATION (City, town, or county) (State) Valley Lee Maryland 23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley ADDRESS Leonardtwn, Md. 24a. REC'D BY REGISTRAR 9/4/56 24b. REGISTRAR'S SIGNATURE Regist. 2			

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. PLACE OF BIRTH [Illegible]		5. DATE OF BIRTH [Illegible]		6. DATE OF DEATH [Illegible]	
7. PLACE OF DEATH [Illegible]		8. CAUSE OF DEATH [Illegible]		9. MANNER OF DEATH [Illegible]	
10. SIGNATURE OF PHYSICIAN [Illegible]		11. SIGNATURE OF CORONER [Illegible]		12. SIGNATURE OF WITNESS [Illegible]	
13. SIGNATURE OF DECEASED [Illegible]		14. SIGNATURE OF NEXT OF KIN [Illegible]		15. SIGNATURE OF BURIAL SOCIETY [Illegible]	
16. SIGNATURE OF MINISTER [Illegible]		17. SIGNATURE OF CHURCH [Illegible]		18. SIGNATURE OF FUNERAL HOME [Illegible]	
19. SIGNATURE OF CEMETERY [Illegible]		20. SIGNATURE OF INTERVIEWER [Illegible]		21. SIGNATURE OF SUPERVISOR [Illegible]	
22. SIGNATURE OF CLERK [Illegible]		23. SIGNATURE OF ASSISTANT CLERK [Illegible]		24. SIGNATURE OF RECEPTIONIST [Illegible]	
25. SIGNATURE OF FILE CLERK [Illegible]		26. SIGNATURE OF INDEXER [Illegible]		27. SIGNATURE OF CHECKER [Illegible]	
28. SIGNATURE OF AUDITOR [Illegible]		29. SIGNATURE OF ACCOUNTANT [Illegible]		30. SIGNATURE OF TREASURER [Illegible]	
31. SIGNATURE OF MANAGER [Illegible]		32. SIGNATURE OF ASSISTANT MANAGER [Illegible]		33. SIGNATURE OF CLERK [Illegible]	
34. SIGNATURE OF FILE CLERK [Illegible]		35. SIGNATURE OF INDEXER [Illegible]		36. SIGNATURE OF CHECKER [Illegible]	
37. SIGNATURE OF AUDITOR [Illegible]		38. SIGNATURE OF ACCOUNTANT [Illegible]		39. SIGNATURE OF TREASURER [Illegible]	
40. SIGNATURE OF MANAGER [Illegible]		41. SIGNATURE OF ASSISTANT MANAGER [Illegible]		42. SIGNATURE OF CLERK [Illegible]	
43. SIGNATURE OF FILE CLERK [Illegible]		44. SIGNATURE OF INDEXER [Illegible]		45. SIGNATURE OF CHECKER [Illegible]	
46. SIGNATURE OF AUDITOR [Illegible]		47. SIGNATURE OF ACCOUNTANT [Illegible]		48. SIGNATURE OF TREASURER [Illegible]	
49. SIGNATURE OF MANAGER [Illegible]		50. SIGNATURE OF ASSISTANT MANAGER [Illegible]		51. SIGNATURE OF CLERK [Illegible]	
52. SIGNATURE OF FILE CLERK [Illegible]		53. SIGNATURE OF INDEXER [Illegible]		54. SIGNATURE OF CHECKER [Illegible]	
55. SIGNATURE OF AUDITOR [Illegible]		56. SIGNATURE OF ACCOUNTANT [Illegible]		57. SIGNATURE OF TREASURER [Illegible]	
58. SIGNATURE OF MANAGER [Illegible]		59. SIGNATURE OF ASSISTANT MANAGER [Illegible]		60. SIGNATURE OF CLERK [Illegible]	
61. SIGNATURE OF FILE CLERK [Illegible]		62. SIGNATURE OF INDEXER [Illegible]		63. SIGNATURE OF CHECKER [Illegible]	
64. SIGNATURE OF AUDITOR [Illegible]		65. SIGNATURE OF ACCOUNTANT [Illegible]		66. SIGNATURE OF TREASURER [Illegible]	
67. SIGNATURE OF MANAGER [Illegible]		68. SIGNATURE OF ASSISTANT MANAGER [Illegible]		69. SIGNATURE OF CLERK [Illegible]	
70. SIGNATURE OF FILE CLERK [Illegible]		71. SIGNATURE OF INDEXER [Illegible]		72. SIGNATURE OF CHECKER [Illegible]	
73. SIGNATURE OF AUDITOR [Illegible]		74. SIGNATURE OF ACCOUNTANT [Illegible]		75. SIGNATURE OF TREASURER [Illegible]	
76. SIGNATURE OF MANAGER [Illegible]		77. SIGNATURE OF ASSISTANT MANAGER [Illegible]		78. SIGNATURE OF CLERK [Illegible]	
79. SIGNATURE OF FILE CLERK [Illegible]		80. SIGNATURE OF INDEXER [Illegible]		81. SIGNATURE OF CHECKER [Illegible]	
82. SIGNATURE OF AUDITOR [Illegible]		83. SIGNATURE OF ACCOUNTANT [Illegible]		84. SIGNATURE OF TREASURER [Illegible]	
85. SIGNATURE OF MANAGER [Illegible]		86. SIGNATURE OF ASSISTANT MANAGER [Illegible]		87. SIGNATURE OF CLERK [Illegible]	
88. SIGNATURE OF FILE CLERK [Illegible]		89. SIGNATURE OF INDEXER [Illegible]		90. SIGNATURE OF CHECKER [Illegible]	
91. SIGNATURE OF AUDITOR [Illegible]		92. SIGNATURE OF ACCOUNTANT [Illegible]		93. SIGNATURE OF TREASURER [Illegible]	
94. SIGNATURE OF MANAGER [Illegible]		95. SIGNATURE OF ASSISTANT MANAGER [Illegible]		96. SIGNATURE OF CLERK [Illegible]	
97. SIGNATURE OF FILE CLERK [Illegible]		98. SIGNATURE OF INDEXER [Illegible]		99. SIGNATURE OF CHECKER [Illegible]	
100. SIGNATURE OF AUDITOR [Illegible]		101. SIGNATURE OF ACCOUNTANT [Illegible]		102. SIGNATURE OF TREASURER [Illegible]	

BUREAU V. 3

SEP 6 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9661
CERTIFICATE OF DEATH

Reg. Dist. No. 69648-282

1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY P. G.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. JAMES		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEAT PLEASANT	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CHESAPEAKE BAY- MARYLAND.		d. STREET ADDRESS 502 - 68th Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BERNARD FRANCIS GUNTOW		4. DATE OF DEATH SEPTEMBER 9, 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/20/1902
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BERNHARDT GUNTOW		14. MOTHER'S MAIDEN NAME MARY L. KESSLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN		16. SOCIAL SECURITY NO.	
17. INFORMANT MARIS F. GUNTOW-		Address 502-68 th Street Seat pleasant, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Immediate DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/9/56 , 19 56 , to 9/9 , 19 56 , that I last saw the deceased alive on 9/9/56 , 19 56 , and that death occurred at 6:15 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Roy Guyther M.D.		ADDRESS (Street, city or town, state) Mechanicsville DATE SIGNED 9/9/56	
PHYSICIAN'S NAME (Type) J. ROY GUYTHER, M.D.		MECHANICSVILLE, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9/10/56	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS, CO.		ADDRESS WASHINGTON, D.C.	
24a. REC'D BY REGISTRAR 9/10/56		24b. REGISTRAR'S SIGNATURE Gerald A. Houser	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09649

282

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Palmers		c. LENGTH OF STAY IN 1b 37 Years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Palmers		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Jefferson Last Jefferson		4. DATE OF DEATH Month September Day 5 Year 19 56	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 1891
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.I.A.	
13. FATHER'S NAME William Young		14. MOTHER'S MAIDEN NAME Frances Bowling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Walter Jefferson		Address Palmers Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardio-vascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 hour. 1 1/2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 55 , to Sept. , 19 56 , that I last saw the deceased alive on 3 Sept. , 19 56 , and that death occurred at 5:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph E. Gill		ADDRESS (Street, city or town, state) Leonardtown, Md. DATE SIGNED 9/6/56	
PHYSICIAN'S NAME (Type) Joseph E. Gill M.D.		Leonardtown Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/8/1956	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart		22d. LOCATION (City, town, or county) (State) Bushwood Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtown Md.	
24a. REC'D BY REGISTRAR 9/17/56		24b. REGISTRAR'S SIGNATURE Glenn A. Hansen	

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SEP 10 1956

BUREAU V

[illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9663 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 4 Film 205 10-11-56 et

09650

Reg. Dist. No. 284

1. PLACE OF DEATH a. COUNTY ST MARYS MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST MARYS			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL NEAR MECHANICSVILLE				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NONE				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THOMAS Middle WILSON Last PILKERTON				4. DATE OF DEATH Month SEPT Day 20 Year 1956			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 28 1926		9. AGE (In years last birthday) 30 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME ALFRED R PILKERTON				14. MOTHER'S MAIDEN NAME CATHERINE FIDAMS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 220-34-8100		17. INFORMANT Address Joseph R Pilkerton, Mechanicsville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CRUSHED CHEST, FRACTURED CERVICAL VERTEBRA DUE TO (b) IMME Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 835X DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) TRACTOR OVERTURNED					
20c. TIME OF INJURY Month, Day, Year 9 JULY 20 1956		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work or while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) FARM		20f. (City or town) MECHANICSVILLE ST MARYS MD (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE J. Roy Guyther				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) J. Roy Guyther				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 24 1956		22c. NAME OF CEMETERY OR CREMATORY St Joseph Cemetery		22d. LOCATION (City, town, or county) Morgantown Md (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home				24a. REC'D BY REGISTRAR SEP 25 1956 24b. REGISTRAR'S SIGNATURE Gleason Carter			

NEW YORK STATE DEPARTMENT OF HEALTH - ALBANY 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. GILSON		45		M		W		JAN 10 1956		NEW YORK CITY	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
100 W. 10th St. New York 14		Clerk		High School		Married		Heart Disease		Natural	
PREVIOUS ILLNESS		SYMPTOMS		DIAGNOSIS		TREATMENT		HISTORY		FAMILY HISTORY	
None		Chest pain, shortness of breath		Myocardial Infarction		None		None		None	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		HOSPITAL		PHYSICIAN	
J. H. Gilson		Jan 10 1956		10:00 AM		New York City		St. Mary's Hospital		Dr. J. H. Gilson	

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09651

9664

CERTIFICATE OF DEATH

Reg. Dist. No.

281

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Valley Lee</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Mary's Hospital</u>		d. STREET ADDRESS <u>Valley Lee</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELLA</u> <u>MARTHA</u> <u>THOMPSON</u>		4. DATE OF DEATH Month Day Year <u>September</u> <u>28</u> <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1876</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>1</u> <u>29</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Allan Hawkins</u>		14. MOTHER'S MAIDEN NAME <u>Jane Coates</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Leroy Thompson</u>		Address <u>Valley Lee, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion (recurrent)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>4 years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 14, 1956</u> to <u>Sept 28, 1956</u> , that I last saw the deceased alive on <u>Sept 27, 1956</u> , and that death occurred at <u>4:10 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J.P. Bean</u> M.D.		ADDRESS (Street, city or town, state) <u>Great Mills, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>J.P. Bean</u> M.D.		DATE SIGNED <u>9/28/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/1/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. George's</u>		22d. LOCATION (City, town, or county) (State) <u>Valley Lee, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u>		ADDRESS <u>Leonardtown, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>9/28/56</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1956 OCT 1

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09652

9665

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>St. Marys</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>St. Marys</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Leonardtwn</u>				TOWN <u>California</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St. Marys Hospital</u>				STREET ADDRESS (If rural give location) <u>Rural</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Joseph Tyrone Thompson</u>				<u>Sept. 7 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
<u>male</u>	<u>colored</u>	<u>single</u>	<u>August 17, 1956</u>			<u>21</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>		<u>-----</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>Weiland H. Parhan</u>				14. MOTHER'S MAIDEN NAME <u>Estell Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>---</u>		<u>Estell Thompson - California, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
764.0 IMMEDIATE CAUSE (A) <u>Bacterial diarrhea</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hydrocephalus</u>				3 wk			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 2, 1956</u> , to <u>Sept 7, 1956</u> , that I last saw the deceased alive on <u>Sept 7, 1956</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>P.J. Bean</u>				ADDRESS (Street, city, town, state) <u>Great Mills, Maryland</u>			
DATE THEREOF <u>9/7/56</u>				DATE SIGNED <u>9/7/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Face Cemetery</u>		LOCATION (City, town, or county) (State) <u>Great Mills, Maryland</u>			
24. REC'D BY REGISTRAR <u>9/7/56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Leonardtwn, Md.</u>			

2078273XV4

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

REG. NO. 110

A DEATH RECORD SHOULD BE MADE FOR EVERY DEATH

NAME OF DECEASED

DATE OF DEATH

ST. MARY'S

RESIDENCE

JOHNS HOPKINS

RACE

ST. JOHN'S HOSPITAL

JOHNS HOPKINS HOSPITAL

CAUSE OF DEATH

HEART DISEASE

SEX

DATE OF BIRTH

JOHNS HOPKINS

PLACE OF BIRTH

JOHNS HOPKINS

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SEP 11 1956

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